



Delivery System Reform in Section 1115 Waivers: A Texas Experience

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Introduction

Many providers across the nation are changing the way they deliver health care and re-envisioning their roles within an increasingly risk dominated environment as payment reform and the transition of fee for service patients into capitated payment plans incentivize the development of integrated health systems. At the same time, national health reform has accelerated the development of policies that link financing with the outcomes for populations – as opposed to the volume of procedures or visits – of care delivery.

Safety net providers generally lack the capital enjoyed by providers who have focused on more lucrative patient populations for the past few decades. At the same time, safety net providers tend to have experience serving large populations of indigent, Medicaid and Dual Eligible patients and may stand to gain large numbers of health insurance exchange and Medicaid expansion patients in the next few years, the majority of which will be covered under managed care programs. It will be critical for safety net providers to develop robust systems to enroll, care for and retain this increasingly informed and empowered consumer base. Therefore, safety net providers are particularly in need of transforming their care model and developing strong capabilities to manage financial risk and deliver more cost-effective services.

A handful of states with recent Section 1115 Medicaid waivers have included a program geared to transform how care is delivered and financially incentivized through Delivery System Reform Incentive Payment (DSRIP) programs. While not all providers may have the chance to participate in a DSRIP program, its model has key elements that can inform business plans and investment opportunities for safety net and community providers across the country. States that do adopt the program can look to those who have been its early implementers for lessons learned. More broadly, the health care industry will gain insight from those DSRIP projects that are successful and result in improved health for various populations.

The purpose of the DSRIP program is to incentivize improvements in care delivery and health outcomes, while changing the paradigm with relation to alignment of financial incentives. It promotes the development of population health-focused integrated systems of care. It does this by providing incentives for providers after they have demonstrated measurable improvements in care. The program is based on the “Triple

Aim” of better care that improves population health at a lower cost.¹ It also aligns with the goals of the Affordable Care Act (ACA) to reward value and incentivize accountability, care coordination, prevention, population health and care management. This policy shift may have long-term impacts on shaping health care markets as its goals promote integrated systems of care and payment reform.

Texas is one of three states currently implementing a DSRIP program.² As Texas has the highest proportion of uninsured residents in the U.S. (24%)³ and is not currently planning to expand its Medicaid program under the ACA, its waiver will play a critical role in reducing the many barriers to health care that uninsured and underserved Texans face.⁴ Texas’ waiver allows hospital providers to sustain the levels of funding previously accessed through the Upper Payment Limit (UPL) supplemental funding program in caring for Medicaid beneficiaries and the indigent.⁵ The difference with the DSRIP program, however, is that payments are now tied to achieving process improvement milestones and clinical outcomes.

This paper describes the DSRIP experience in Texas’ Fort Worth area (“Region 10”). Region 10 is one of the largest of the Texas DSRIP regions and covers Tarrant County, which includes Fort Worth and surrounding metro areas, as well as eight other counties. First, the paper gives an overview of the Texas waiver. Second, the Region 10 DSRIP plan is described. Finally, the paper provides observations and recommendations based on the development of the Region 10 DSRIP plan. The lessons learned from Region 10 will be informative for others across the country looking to the future and contemplating alignment of investment dollars, delivery system redesign and payment reform.

Context

Recent decades have seen the refinement and wider adoption of quality and performance improvement approaches and efforts, as well as the testing of pay-for-performance and other similar models. The federal government as a payer and policy maker has been shifting away from the traditional fee-for-service model and UPL programs, and in its place is piloting a variety of approaches from the expansion of

¹ The “Triple Aim” framework developed by the Institute for Healthcare Improvement, <http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx>. Berwick, Don M., Thomas W. Nolan, and Thomas Whittington. "The Triple Aim: Care, Health, And Cost." *The Triple Aim: Care, Health, And Cost* 27.3 (2008): 759-69. *Health Affairs*. Health Affairs. Web. 04 June 2013.

² California and Massachusetts are also implementing DSRIPs (or DSTI as it is called in Massachusetts). New Jersey and Kansas have approved Section 1115 waivers that include DSRIP programs, which are under development.

³ Census Bureau Current Population Survey 2011.

⁴ The Medicaid expansion was initially a mandatory key component of the Patient Protection and Affordable Care Act (PPACA). The landmark 2012 Supreme Court Decision, *NFIB v. Sebelius*, rendered Medicaid expansion a voluntary aspect of the PPACA left up to State discretion.

⁵ The 2011 Section 1115 Medicaid waiver replaced Texas’ Medicaid Upper Payment Limit (UPL) programs for services under managed care capitation and for residual fee-for-service Medicaid services.

managed care and capitation to new payment models (e.g., bundled and global payments).

The Obama Administration has accelerated these trends: former director of the Centers for Medicare and Medicaid Services (CMS), Donald Berwick, MD, instilled the Triple Aim as a guiding framework for the agency and the ACA is changing the health care system through reformed insurance policies and programs, expanded coverage and delivery system improvements. Consistently, recent Section 1115 Medicaid waivers have moved away from prior finance-based models to ones based on earning payment through improvements and cost savings.

Texas Waiver Overview

Billions of dollars of UPL supplemental funding that Texas hospitals had come to increasingly rely on were projected to end with the state's plans to move all Medicaid beneficiaries into managed care. However, the five-year 1115 waiver approved by CMS in 2011 for Texas seeks to improve health care delivery and preserve the prior levels of Medicaid UPL funding through two pools worth up to \$29 billion:

1. The Uncompensated Care (UC) pool reimburses hospitals and other institutional providers for services eligible as uncompensated care costs (mainly Medicaid and indigent care) based on allowable cost and payment data from the Medicare cost report (estimated at \$17.6 billion over five years); and
2. The DSRIP pool makes incentive payments to providers who have improved care and outcomes based on program requirements. Its funding is limited at approximately \$11.4 billion over five years.

The percentage of funding assigned to the UC pool will decrease over the five years proportional to the increase in DSRIP funding during that time in order to take into account ACA implementation and to shift priority to a pay-for-performance financing model.

What is unique about Texas' waiver is that these two pools hinge upon not only individual hospital transformation, but a regional structuring of providers that include hospitals, physician groups, public health departments and mental health agencies. The regional health plan approach is designed for coordination among regional providers on the basis of community need, integrated financing mechanisms and a focus on regional learning collaboratives and performance improvement. The implementation of the waiver will demonstrate whether the regions' identification of common community health needs resulted in performing providers working more closely together on improving population health.

Regional Structure of Texas' Waiver

The unique regional governance structure of Texas' waiver is primarily based on historic financing arrangements, which set a precedent of public entities providing non-federal Medicaid share for private institutions. Consequently, the waiver divides Texas into 20

contiguous, non-overlapping multi-county regional groupings for the purposes of developing Regional Healthcare Partnerships (RHPs). Each regional grouping has a public hospital or, if the RHP does not contain a public hospital, a local government entity⁶ that serves as the “anchor.” The anchor is the region’s single point of contact with the State and CMS and coordinates the RHP’s activities for the duration of the waiver.⁷ More than 300 Medicaid providers are participating in RHPs. These “performing providers” include private (non-profit and for-profit) and public hospitals, some public health departments, health districts, certain physician groups and 38 local mental health authorities.

In Region 10, the anchor is John Peter Smith (JPS) Health Network, a health district with a 450-bed trauma center, more than 40 ambulatory care clinics, multiple affiliated physician groups, the sole inpatient mental health facility in Tarrant County and an indigent care program called Connections that provides coverage for more than 45,000 indigent patients. Participating providers within Region 10 are a diverse group including five large acute care hospital systems, two children’s hospitals, the University of North Texas Health Sciences Center (UNTHSC), rural district hospitals, physician groups, mental health agencies and the Tarrant County department of public health (in total 28 providers).

Design of Texas’ DSRIP

The DSRIP program explicitly links payments with measurable outcomes, building upon recent federally incentivized care transformation models. DSRIP incentive payments are made for: (1) each region’s identification and design of projects that transform the region’s delivery systems based on community need (first year funding); and (2) a provider’s achievement of the milestones and outcomes specified in the provider’s projects from the RHP plan (measurable process improvements and targeted health outcomes).⁸ Furthermore, Texas’ DSRIP funding is contingent upon provision of the non-federal share by a qualifying entity other than the State. Not achieving a milestone means a provider risks losing the associated funding and any investment made toward a given milestone and outcome.

The Texas DSRIP program includes projects focused on improving quality and lowering the cost of care for defined populations. Projects are organized into four categories:

1. Infrastructure Development: improvements in technology, tools and human resources;
2. Program Innovation and Redesign: improvements in care delivery;

⁶ Either a hospital district, hospital authority, county or State University.

⁷ See “Presentation to House County Affairs Committee on Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Update,” by Thomas Suehs, Executive Commissioner, and Billy Millwee, Deputy Executive Commissioner for Health Services Operations, Texas Health and Human Services Commission, January 17, 2012.

⁸ Texas 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program, No. 11-W-00278/6, STC

3. Quality Improvements: improvements in patient's outcomes; and
4. Population-Focused Improvements: reporting on a common set of more than 80 care measures.

Each RHP had to submit a DSRIP plan in the first year of the waiver that committed to improvements over the next four years of the waiver. Individual performing providers in an RHP had to include at least one project for improvement in the RHP plan, selected from a menu across the first two categories (Infrastructure Development and Program Innovation and Redesign). Some project examples include: transforming primary care clinics for low-income populations into patient centered medical homes, implementing disease registries to enable care management for the chronically ill (such as diabetes), and establishing care transitions from inpatient to ambulatory care setting. Within each project, the provider selected an intervention as well as specific milestones to include in the plan as the basis for incentive payments.

In addition, all of these projects had to be linked to the achievement of improved outcomes selected from the third category (Quality Improvements), such as improved cholesterol management, reduced readmission rates and fewer low birth-weight babies. Finally, hospital performing providers must all report the same set of 82 metrics from the fourth category (Population-Focused Improvements), which includes measures such as potentially preventable conditions, admissions and readmissions, among others.⁹ The projects must focus on care for Medicaid/uninsured populations, and projects must be selected based on demonstrated community health needs from a regional assessment.

Specifically, RHPs were required to include the following in their plan:

- A regional community health needs assessment;
- A minimum number of DSRIP projects, process milestones, improvement milestones, outcomes, and reporting metrics;
- Broad community engagement, accountability and transparency;
- Participation in learning collaborative activities; and
- Individual milestone and project valuations based on funding allocation specifications between and within RHPs and the ability of a provider to identify a source of non-federal share.

In developing their projects, providers were encouraged by the anchor to select projects that aligned with their institutional strategies. The program challenged providers to design projects that stretched the provider in scope and reach. Additionally, the Texas waiver strongly recommends providers participate in regional learning collaboratives and requires participation in a state-wide collaborative. While the regional structure of the waiver was devised for administrative and financing purposes, it may also serve as a platform for more care coordination across multiple systems with common community health goals; in the very least, providers within the RHP must communicate throughout the waiver process.

⁹ Texas 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program, No. 11-W-00278/6, Attachment I: Regional Healthcare Partnership (RHP) Planning Protocol (October 2012).

Overview of Region 10 DSRIP Plan

The Region 10 community health needs assessment highlighted important regional needs that served as the basis for projects selected for inclusion in the DSRIP plan.¹⁰ Each performing provider selected relevant projects consistent with institutional goals and these regional health needs (Categories 1 and 2) as well as identified measurable clinical outcomes to be achieved as a result of conducting the DSRIP projects (Category 3). Significant time was spent developing project plans, including selecting the most appropriate project milestones upon which payment is based. Providers also needed to value their projects, based on factors such as their allocation of funding, the amount of local non-federal Medicaid share available to them, the scope and reach of the project, and the number of patients that would be impacted by the project.

At the end of this arduous process, Region 10 submitted a transformation plan. A total of 28 providers participated in the Region 10 RHP, and each submitted projects for a total of a proposed \$1.1 billion in DSRIP incentive payments. Region 10 submitted 111 projects to improve care and address its community needs of increased Medicaid provider capacity, care coordination and access to health care, especially primary care and mental health services (among other community health needs).

Summary of RHP10 Community Health Needs:

- Lack of provider capacity
- Shortage of primary care services
- Shortage of specialty care
- Lack of access to mental health services
- Insufficient integration of mental health care in the primary care medical system
- Lack of access to dental care
- Need to address geographic barriers that impede access to care
- Lack of access to health care due to financial barriers
- Need for increased geriatric, long-term, and home care resources
- Overuse of emergency department services
- Need for more care coordination
- Need for more culturally competent care
- Need for patient education programs
- Lack of access to healthy foods
- Need for more education, resources and promotion of healthy lifestyles
- Higher incidence rates of syphilis and chlamydia
- Incomplete management of chicken pox and whooping cough cases

Summary of Region 10 DSRIP Proposal

The following summarizes the regional plan submitted, which is still under review and approval by CMS:

| Project Area | # of |
|--|------|
| Expand Chronic Care Management Models | 15 |
| Expand Primary Care Capacity | 12 |
| Apply Process Improvement Methodology to Improve Quality/Efficiency | 9 |
| Implement Evidence-Based Disease Prevention Programs | 9 |
| Enhance Service Availability of Appropriate Levels of Behavioral Health Care | 8 |
| Implement/Expand Care Transitions Programs | 8 |
| Establish/Expand a Patient Care Navigation Program | 7 |
| Expand Specialty Care Capacity | 5 |

¹⁰ For the full community health needs assessments, please see: <http://www.rhp10txwaiver.com>.

| | |
|---|---|
| Integrate Primary and Behavioral Health Care Services | 4 |
| Provide an Intervention for a Targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting | 4 |
| Redesign to Improve Patient Experience | 4 |
| Enhance/Expand Medical Homes | 3 |
| Increase Training of Primary Care Workforce | 3 |
| Introduce, Expand, or Enhance Telemedicine/Telehealth | 3 |
| Develop Care Management Function That Integrates Primary and Behavioral Health Needs of Individuals | 2 |
| Development of Behavioral Health Crisis Stabilization Services as Alternatives to | 2 |
| Enhance Performance Improvement and Reporting Capacity | 2 |
| Implement Evidence-Based Health Promotion Programs | 2 |
| Provide Virtual Psychiatric and Clinical Guidance to All Participating Primary Care Providers Delivering Services to Behavioral Patients Regionally | 2 |
| Enhance Urgent Medical Advice | 1 |
| Establish Improvements in Care Transition from the Inpatient Setting for Individuals With Mental Health and/or Substance Abuse Disorders | 1 |
| Implement a Chronic Disease Management Registry | 1 |
| Increase, Expand and Enhance Oral Health Services | 1 |
| Recruit, Train and Support Consumers of Mental Health Services to Provide Peer Support | 1 |
| Redesign for Cost Containment | 1 |
| Use of Palliative Care Programs | 1 |

Twenty-two of these projects were submitted by the anchor, JPS Health Network, 14 by UNTHSC, eight by the Tarrant County Public Health department and six by the local mental health authority. All other providers submitted between one and five projects, or on average 2.7 projects.

The results of this work include outcomes such as: increasing appropriate utilization of the emergency department, improving quality of life, improving diabetes care, increasing patient satisfaction and reducing mortality from sepsis.

Of the requested total amount, 4.5% was for plan creation, 75.3% was for Infrastructure Development and Innovation and Redesign, 15% Quality Improvements and 5.2% reporting on the set of Population-Health Improvements measures.

Current Status of the RHP Plan

RHP plan development overlapped with the state-federal negotiated development of the program requirements. Additionally, the program requirements have continued to evolve even after plan submission and during their initial CMS review. Consequently, while RHP plans were submitted in December 2012, their full approval by CMS may not be achieved until potentially as late as March 2014. By June 2013, all 20 Texas RHP plans were reviewed and “initially approved” by CMS and the State. This initial approval was limited to funding for the first three years of the waiver for projects that were approved in full or with partial values. Region 10 had 84% of its plan initiatives partially or fully approved resulting in 79% of the requested dollars approved for the first three waiver years. For projects with partial or no approval, performing providers had to choose between making the projects viable or foregoing them. Significant work remains

to complete redrafting and correction of projects that were partially or not approved and in completing baseline patient population and procedure volumes necessary for quantifying payments for years 4-5 of the waiver. The results of CMS' review of RHP plans for years 4-5 is expected by September 2013.

At the same time, additional efforts are needed to complete plan elements not completed with the original plan submission and to catch up on delayed payments for the DSRIP projects and uncompensated care. The most significant effort required for plan completion is the drafting of comprehensive learning collaborative plans and building the necessary infrastructure to drive knowledge transfer and spread clinical practice improvement throughout each region. Such requirements are due to CMS by October 1, 2013. With respect to funding, performing providers have had to choose to deploy significant resources to operationalize the DSRIP projects without assurance of when payments would be made for milestones achieved. With waiver year 2 payments for UC and DSRIP nearly one year behind, providers have struggled meeting cash flow requirements of the waiver. The State has provided performing providers with a glide path that begins to expedite payments over the next six months. During that time, providers will continue with DSRIP project implementation, consider new projects to be funded with unclaimed DSRIP allocations for waiver years 3-5, and reconcile all plan modifications and corrections to the originally submitted RHP plan by March 31, 2014.

Anchor Entity Considerations: Challenges, Opportunities, Trade-Offs

The anchor role is multifaceted and challenging. Beyond participating in the DSRIP like other performing providers, anchoring public hospitals have substantial administrative and communication responsibilities, including setting the tone for the region and encouraging both individual and regional care transformation and collaboration, provider readiness for and participation in payment reform and sharing of best practices through learning collaboratives. In some cases, this role includes coordinating waiver activities among hospitals that historically have perceived each other as competitors. Furthermore, anchor entities participate in their RHP as providers of the non-federal share, which must come from a public source. The anchor is often the single largest source of state matching funds and acts as a major funding source for the region. Anchors must determine how much of their local funding can be used to draw down federal dollars for their own DSRIP projects as well as how much is available to provide the non-federal share for non-public providers. As a result, anchors have noticeable prominence since their local funding serves as a vehicle through which private hospitals are able to participate in the UC and DSRIP funding pools.

To be effective, the anchor entity must position itself as an effective leader and facilitator for transformation. This requires organizational strategies and competence in stakeholder engagement, demonstrating an ability to establish and lead a complex regional planning framework, and coordinating the dissemination, analysis and feedback of DSRIP requirements as they are proposed and developed by CMS and the State. The anchor must be mindful of constituents who may be impacted but not actively participating in the process while ensuring the inclusion of providers of different

types and varying planning competencies. This requires the anchor to be nimble in the execution and development of the RHP plan and to facilitate and model transparency in all regional coordination and decision-making activities.

Lessons Learned from Region 10 Planning and Pre-Implementation

This section provides observations and recommendations based on the development of the RHP plan by the Region 10 stakeholders, including the anchor entity, JPS Health Network, and other performing providers.

Effective plan development is an all-consuming effort.

Each interviewed Region 10 performing provider stressed the significantly greater than anticipated time commitment required to fully participate in the RHP during the regional community health needs assessment and project development processes.

Furthermore, all providers indicated that the large amount of ongoing project revision, stemming in large part from the lengthy process of negotiation and finalization of the protocols and DSRIP menus between the State and CMS, increased the difficulty of participating. Of course, being a part of a program co-developed by CMS and the State is expected to require additional, iterative processes.¹¹ In addition, because the DSRIP program is so much more than a means to achieve financing, as its purpose is to truly change how care is delivered, it requires significant institutional planning efforts. The combination of “sweat equity” by the participating providers, the opportunity to transform care delivery with incentive dollars, and the lack of a “plan B” replacement for the UPL program all resulted in the cooperative effort needed to complete a comprehensive plan in the limited time allotted.

For providers like JPS Health Network who submitted projects across their entire system and are undertaking significant transformation through the DSRIP, this required substantial work across multiple departments, including interdepartmental collaboration and coordination. The planning effort in and of itself, in other words, was an initial step for an organization to begin better care coordination practices and the development of system-wide collaborative teams. Furthermore, conducting the community health needs assessment and developing the broader RHP plan required coordination among Region 10 providers and created a view of the community that was both broad and focused that helped to guide the development of the individual provider projects. Finally, providers who are participating in a DSRIP program should note the experience of Region 10 demonstrates that plan development necessitates an evolving, iterative process.

Recommendations:

- Take the time to conduct the in depth, full scope planning necessary to implementing multiple large-scale system-wide initiatives within a condensed

¹¹ The iterative nature of the process resulted from: (1) the fact that the DSRIP program protocols were being negotiated simultaneous to the development of the RHP plans; in other words, the program requirements were evolving, so plans needed to be changed accordingly; and (2) the layered governance structure of provider to RHP anchor to the State to CMS.

time period. The DSRIP projects should be developed and aligned as part of a larger organizational strategic and business plan.

- As modeled through the DSRIP program, begin this process with conducting a community health needs assessment, which serves to direct the focus of the institutional plan on what the patient population needs the most.
- Prioritize those projects that are most likely to result in real care improvements and impact key patient groups or a significant proportion of the patient population.
- Understand who is impacted outside the “patient, doctor and hospital triangle” and determine how to engage them in the transformation process.
- Look to the DSRIP program menu of projects as an excellent source of replicable care delivery models. Whether or not a provider is participating in a DSRIP program, its menu of projects and milestones provides a current literature review of best practices, tested models and evidenced-based approaches.
- Consider and develop a plan for leveraging DSRIP care delivery transformation in a marketplace that will have a significantly higher percentage of health care consumers in managed care plans.

The transformation team affects the process and results of this endeavor.

Developing the right team to drive the development of the DSRIP plan as well as a communication strategy for clinicians and staff may take time through trial and error. One provider noted they initially wasted time and resources because they felt they had the wrong internal staff and executives involved. Another provider with two different types of employed clinicians – researchers and those who are solely practitioners – found that different types of explanations and financial objectives were necessary to motivate them. Finally, several providers interviewed indicated that the level of clarity provided by the anchor, JPS Health Network, and its technical assistance team (in RHP 10’s case, COPE Health Solutions¹²) was a major determinant in successfully facilitating the plan development process.

Recommendations:

- Assemble a superstar team of clinicians, operations and finance leaders so that the organization is set up for success.
- Select DSRIP champions and owners who understand, and are willing to accept, the risk of using innovative thinking as a tool to change the status quo. This requires significant coaching and mentoring of health care leaders on how to be nimble and flexible yet maintain the fortitude to work through the change process with impacted stakeholders.
- Designate a champion and owner for each project, and make sure that part of that person’s job is to collaborate with other project champions.
- Designate a leader to oversee the entire planning process, supported by adequate project management staff in synthesizing information, coordinating many people and projects, and time management.
- Develop a concerted plan to incorporate and motivate physicians and staff across the organization.

¹² For more information, please see: <http://www.copehealthsolutions.org>

- Have the team report to and stay engaged with the CEO. Leadership must be fully engaged in driving the process because this effort requires vision, organization-wide strategic planning and transformation as well as the accompanying cultural change, and resource management.
- Hands-on knowledgeable technical support is critical to facilitate project development and design activities, especially for providers who are part of a DSRIP program, which involves a high number of complex requirements that evolve with the program.

The effort must be financed and sustain long-term improvements.

Providers participating in a DSRIP program should note that DSRIP payments received by providers may not necessarily be new or additional resources for participating providers. Furthermore, DSRIP payments are tied to project implementation success and reporting specified metrics. Providers must fully understand the risks and be willing to completely commit to the success of their DSRIP projects and to the financial risks associated with clinical accountability. Overall, transformation requires significant investment upfront while cost savings are typically not realized until years later. While financial incentives and potential gain are attractive components of the DSRIP funding, providers must temper their cash flow expectations early in the process as it may take time for a state and CMS to establish complex new payment methodologies. Additionally, applicable to the regional DSRIP approach, the anchor responsibility requires significant time and resources to fully engage communities and stakeholders, conduct the community health needs assessment, coordinate and disseminate information to the region’s providers and provide technical assistance to providers.

Recommendations:

- Select projects that are aligned with and provide the clinical and payment transformation building blocks for a well thought out strategic and business plan.
- Develop capacity and capabilities to manage financial risk over time so that delivery system transformations can be most effectively leveraged through proper alignment of financial incentives and so that cost savings from reduced utilization of expensive services can be re-invested in long-term sustainability of new care delivery models such as care transitions, call centers and other critical components of a population health focused system of care.
- Consider adopting a system-wide approach to quality improvement, such as Lean, Six Sigma and/or the Institute for Healthcare Improvement Model for Improvement.
- Future waivers should consider and incentivize alternative sources of non-federal share that can avoid conflicts among providers and promote broad participation.

Usable data must be collected and analyzed in order to drive performance improvement.

Participating in the DSRIP program can require reporting on 100+ measures. Population definition is critical and much more complicated than originally expected. It is important that the measures represent reality so that improvements can actually be informed and driven by the data. Many Medicaid providers lack electronic health

records or are currently implementing them. A lack of robust, accurate data can seriously impede the progress of transformation. The availability of structured, usable and accurate data can make an empirical difference.

Recommendations:

- If data is not available electronically, prioritize implementing electronic health records.
- Identify data gaps and needs, in terms of technology and people, and make plans to address those.
- Ensure the ability to collect baseline data for DSRIP projects in the first two years.
- Build into the DSRIP plan the technology, tools and human resources to generate the data reporting and analysis needed.

Learning collaboratives provide an ongoing opportunity to engage participating providers in reaching common goals.

Participating providers indicated that they hope to benefit from other providers' experiences in implementing their projects and to share insights based on their own successes and setbacks. Several providers noted that the planning, ongoing communication, and convening costs associated with developing and maintaining effective regional learning collaboratives will most likely be incurred primarily by the Region 10 anchor entity. Many providers also indicated that they will convene their own institution-specific internal learning collaboratives to ensure that lessons learned through DSRIP projects are translated to the rest of the provider's programs and populations. CMS has emphasized the importance of learning collaborative participation for the DSRIP program.

Recommendations:

- Identify existing learning collaboratives that incorporate best practices for performance improvement and information sharing in order to accelerate improvements by building on others' successes and learning from their setbacks.
- Consider how to best promote collaboration and information-sharing among market competitors, perhaps in a way which emphasizes that institutional interests may be best served by working together to address community needs.
- Consider whether new learning collaboratives should be launched, and if so, emphasize improvement and sharing over teaching.
- Regional learning collaboratives must be adequately funded and staffed in order to drive and support systemic transformation across regional systems of care. They offer an ongoing opportunity for provider systems to continue to build regional relationships of trust, collaboration, and clinical transparency and to encourage and promote regional population-based improvements.
- States adopting a DSRIP program may consider how to best invest in learning collaboratives.

Community engagement can help shape the plan.

A critical aspect of the RHP plan development process was community engagement, including multiple opportunities for public input on plan development. In Region 10, this process included conducting a survey to identify local community health needs and concerns in each of its nine counties as well as “town hall” type meetings for presenting survey findings and secondary data in order to solicit feedback. Region 10 worked extensively to develop a broad set of performing providers. Nonetheless, underlying differences related to rural versus urban demographics and rural provider shortages resulted in a final RHP plan dominated by projects proposed by urban providers.

Another component of the community engagement process was ensuring the understanding and engagement of the local medical community and government partners, particularly concerning the role that local funds will play in providing the non-federal share. According to one elected county official in Region 10, “For the most part counties are concerned that they are less able to ensure that the dollars they put in [for disproportionate share] federal match will be returning to their county [under the waiver].” He also indicated that he believed that Region 10 had a relatively small amount of resistance to DSRIP participation as a result of pre-existing good working relationships between the public and private hospitals. Nonetheless, he pointed out that provider resistance to the potential loss of supplemental dollars continues to be a factor at the state level.¹³

The regional approach presents challenges and opportunities.

- The regional anchor’s role is multi-faceted and includes both significant challenges and opportunities. Pre-existing levels of cooperation and openness between a region’s providers are an important early indicator of regional success.
- Spend time understanding each performing provider’s perspective on risk. DSRIP projects reward providers for meeting established milestones and outcomes. Academic institutions struggle with this risk component of DSRIP as they often view the funding similar to a grant whereby a DSRIP intervention is a hypothesis to be proven right or wrong, whereas a provider must actually prove the hypothesis right in order to receive DSRIP funding.

Conclusion

The DSRIP program provides a model for providers to engage in innovative solutions to solving access and care coordination issues. In the very least, it contains a current and in depth literature review of industry best practices and care improvement models, as well as the future delivery system vision of CMS. Current DSRIP programs can demonstrate providers’ successes and challenges with improvement work in a short period of time. The insights from Texas’ Fort Worth region’s Medicaid providers are valuable to others engaging in planning organizational transformation in how care is delivered to and financed for Medicaid and uninsured populations.

¹³ Texas HB 1145, Feb. 11, 2013.

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